S. No. 2
M—2-43
5-17-39
I X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35758

FILED OCT 19 1943

Registration District No. 3317 Primary Registration District No. 3069 Registrar's No. 2289

1. PLACE OF DEATH:
(a) County St. Louis County
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dunklin
(c) City or town Senath
(If outside city or town limits, write "RURAL")
(d) Street No. .....
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country /

3. (a) PRINT FULL NAME Mary Millicent McFarland
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Child
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased December 24 (Month) 1941 (Day) (Year)

8. AGE: Years 1 Months 9 Days 14 If less than one day ..... hr. ..... min.

9. Birthplace Kennett (City, town, or county) Mo. (State or foreign country) 0
10. Usual occupation Child
11. Industry or business .....

FATHER
12. Name Homer W. McFarland
13. Birthplace Gibson (City, town, or county) Mo. (State or foreign country) 0

MOTHER
14. Maiden name Flossie Starnes
15. Birthplace Gibson (City, town, or county) Mo. (State or foreign country) 0

16. (a) Informant H. W. McFarland
(b) Address Senath, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-8-43 (Month) (Day) (Year)
(c) Place: burial or cremation Hayti, Mo.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) OCT 12 1943 (Date received local registrar) C. L. McGavran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8
year 1943 hour 1 minute 25 A.M.
21. I hereby certify that I attended the deceased from Oct 6 her 1943 to Oct 8 1943;
that I last saw her alive on Oct 7 1943;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Aspiration pneumonia	6hrs.
Due to: Inability to swallow-	
Due to: Spastic quadriplegia & associated maldevelopment of Brain	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Cortical malformation - Cerebrum	

151d

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature Wm. C. Macdonald (M. D. coroner)
Address 132 S. Main Date signed 10-8-43

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed John Olszewski

Licensed Embalmer No. 3398

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.